SULLIVAN, NOLAN & ASSOCIATES PC -- REGISTRATION FORM

NOTE: NAMES, DOB, AND ADDRESS MUST MATCH WHAT YOUR INSURANCE COMPANY HAS ON FILE

***Legal Name*:**_____**Preferred Name**_____ **DOB :** _____

Address:_____**City:**_____**State:**_____**Zip**_____

Phone (_____)_____ **Work Phone (_____)** _____ **ADULT CELL PHONE(_____)**_____

Email _____ **Primary Care Physician:**_____

Whom may we thank for referring you? _____

Have you been seen in this office before? ☐ **YES** ☐ **NO Dr:**_____

Have you seen any other Mental Health Care provider since January? ☐ **YES** ☐ **NO Name:**_____

Is another member of your household a patient with this practice? If so, who? _____

If Patient is a Child: Parent(s) or other Financially Responsible Adult

Parent Information

Legal Name _____***Date of Birth***_____

Relationship to Patient: ***Place of Employment:***_____

Address if different from Patient:_____**City:**_____**State:**____**Zip**_____

Phone (_____)_____ **Work Phone (_____)** _____ **Cell Phone (_____)**_____

Should this person receive copies of statements? ☐ **YES** ☐ **NO**

Parent Information

Legal Name _____***Date of Birth***_____

Relationship to Patient: ***Place of Employment:***_____

Address if different from Patient:_____**City:**_____**State:**____**Zip**_____

Phone (_____)_____ **Work Phone (_____)** _____ **Cell Phone (_____)**_____

Should this person receive copies of statements? ☐ **YES** ☐ **NO**

Other's Information

Legal Name _____***Date of Birth***_____

Relationship to Patient: ***Place of Employment:***_____

Address if different from Patient:_____**City:**_____**State:**____**Zip**_____

Phone (_____)_____ **Work Phone (_____)** _____ **Cell Phone (_____)**_____

Should this person receive copies of statements? ☐ **YES** ☐ **NO**

PLEASE COMPLETE BOTH PAGES

FINANCIALLY RESPONSIBLE PARTY

I understand that full payment is required at the time of service and that I am fully responsible for the fee regardless of insurance coverage. Sullivan, Nolan and Associates can only file insurance with which they participate. I authorize Sullivan, Nolan and Associates and their billing agency (Michelle's Billing Service) to communicate with my insurance company as needed for verification and claim processing.

Signature:_____Date:_____

***PRINT Legal Name*:_____ Phone: (____)_____**

EMAIL (Optional):_____

For Office Use Only

Date: _____

Referred From _____ To _____

DX _____ DR_____